Division of Health Care Facilities

PRINTED: 07/16/2010
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1915	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON HEALTHCARE	431 LARKIN SPRING RD MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	120)-8-6 No Deficiencies Based on observation during the survey conducted on 7/13/10, it was determined, the facility had no fire safety deficiencies.	N 002		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Phillip Cleary, E.D. TITLE (X6) DATE 7/28/10

STATE FORM 6099 HGDN21 If continuation sheet 1 of 1